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A Case Report of Appendicovesical Fistula

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Abstract

Appendicovesical fistulae are rare and occur secondary to acute or missed acute appendicitis. A 52 years old lady presented with isolated faecaluria, gross fecal contaminated wine or fresh contaminated urine. The presentation and management of appendicovesical fistula is discussed.

Keywords: Appendix; Urinary bladder; Fistula.

Case Discussion

52 years old lady presented with isolated faecaluria, gross fecal contaminated wine or fresh contaminated urine, it was the present disease symptoms she was not catheterized with no precious episodes of acute appendix, she did not have fever with chills and rigors. She has only dysuria; examination of the patient was not contributory. There was no ascitis, no mass, and no tender point. Pelvic examination: vagina free, cx mobile, no mass, no tenderness on mobility of cx Urine analysis: show Gross fecal matter with pyuria. USG: revealed No gas in the bladder but mixed echogenicity is

CECT:I) An enhanced small mass with gas and hyper dense lesion in the bladder. 2) Rest of the abdomen was reported normal Cystoscope: reeve an opening in the dome of the bladder. Exploratory laporotomy revealed omental adhesion wrapping appendix entering into the bladder. The base of the appendix, Caecurn, Ileum was normal. There was no significant mesenteric nodes, no diverticulitis coli. There was no other mass in siginoid and any part of colon. Enblock resection with the wedge of bladder and complete appendix resented.

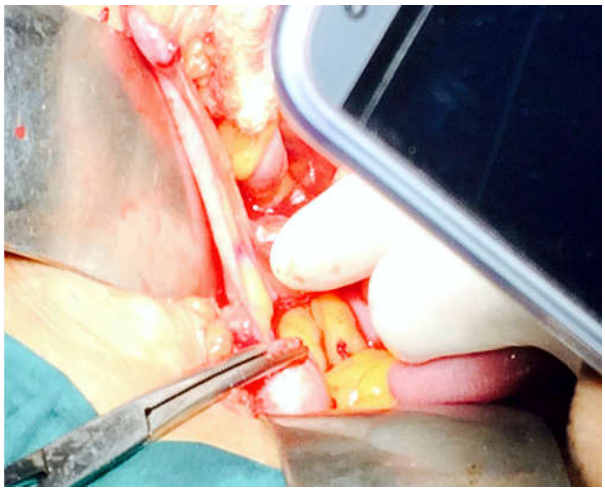

Fig. 1:

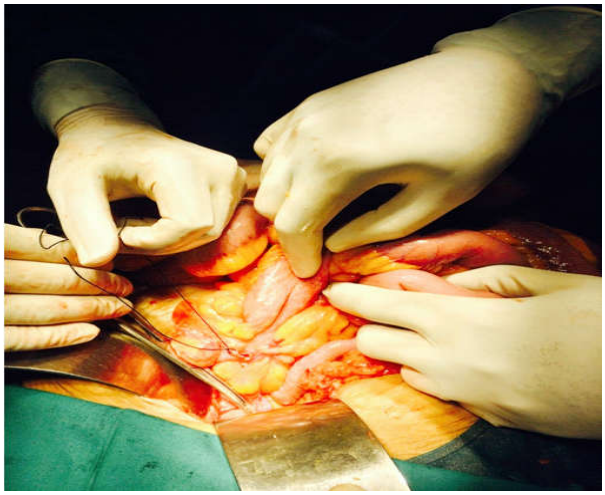

Fig. 1:

Post OP Finding

Laparotomy done under GA, midline incision was taken peritoneum was opened.

Intra OP Finding

There was mass in RIF which was attached to the right dome of bladder the mass was dissected the additions were released and there was a tubular structure which was connected to the cecum and the bladder. (Tubular structure was appendix) the bladder was dissected and bladder was repaired in layers with an SPC in situ and cecum repair was done with 3 0 silk, after complete hemostasis drain was placed and abdomen was closed under layers.

The specimen was sent for HPR

Conclusion

The ceacum was draining into the bladder through appendix.

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